

Application Form 2009-2010

Please read the relevant application guidelines before completing this form

Clinical Supervision Grants Program

Initiative funded by the Department of Human Services

Application Summary

Lead Agency Name

Partnering Agency Name(s)

1.

2.

3.

4.

5.

Number of Clinicians to undertake training:

Lead Agency	No.	<hr/>
Partner 1.	No.	<hr/>
Partner 2.	No.	<hr/>
Partner 3.	No.	<hr/>
Partner 4.	No.	<hr/>
Partner 5.	No.	<hr/>
	Total:	<hr/>

Name of Training Course

Total amount sought through grant program

\$

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Lead Agency Details

Agency Name _____

DHS Region _____

Contact Person _____

Postal Address _____

City _____

State _____

Postcode _____

Telephone _____

Email _____

Agency Endorsement

A letter of support from the lead agency Chief Executive Officer must be provided with the application

Clinician's Details (Please print additional pages if necessary)

Title Miss Ms Mrs Mr Dr Other _____

Given Name(s) _____

Surname _____

Position _____

Discipline _____

Employment details (hours per week) _____

Title Miss Ms Mrs Mr Dr Other _____

Given Name(s) _____

Surname _____

Position _____

Discipline _____

Employment details (hours per week) _____

Title Miss Ms Mrs Mr Dr Other _____

Given Name(s) _____

Surname _____

Position _____

Discipline _____

Employment details (hours per week) _____

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Partnering Agency Details *(Please print this page for each partnering facility)*

Agency Name _____

DHS Region _____

Contact Person _____

Postal Address _____

City _____

State _____

Postcode _____

Telephone _____

Email _____

Agency Endorsement

A letter of support from each partnering agency Chief Executive Officer must be provided with the application

Clinician's Details

Title Miss Ms Mrs Mr Dr Other _____

Given Name(s) _____

Surname _____

Position _____

Discipline _____

Employment details (hours per week) _____

Title Miss Ms Mrs Mr Dr Other _____

Given Name(s) _____

Surname _____

Position _____

Discipline _____

Employment details (hours per week) _____

Title Miss Ms Mrs Mr Dr Other _____

Given Name(s) _____

Surname _____

Position _____

Discipline _____

Employment details (hours per week) _____

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Course Details

Name of Training Course

Training Course Provider

Date(s) (if known)

Location

Qualification/ recognition at end of course

Course Costs

Item	Unit Price	Participating Clinicians ¹	Total
Course Costs			
Backfill ²			
Accommodation ³			
Travel ⁴			
Study Resources			
Other (please specify)			
Total			

1. Please note that the number of participating clinicians may vary for each budget item. This is due to the fact that backfill, accommodation, and/or travel may not need to be paid for each participating clinician.

2. The unit price should be calculated as the total cost for all participants divided by the total number of participating clinicians.

3. Accommodation expenses will be considered for reimbursement at a rate of up to \$100 per night irrespective of location (rural or metro).

4. The full cost of car travel expenses will be considered on a return trip from each participating clinician's usual place of residence via the most direct and practical route. The reimbursement rate is 49 cents per km. The total cost of travel should be determined and divided by the total number of participating clinicians to determine the unit price.

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Funding Sources

Employer/Facility contributions (including backfill, accommodation, etc)

Facility 1	\$
Facility 2	\$
Facility 3	\$
Facility 4	\$
Other funding sources	\$
Sub-total	\$
<hr/>	
Amount sought through clinical supervisor grant program	\$
<hr/>	
TOTAL FUNDING SOURCES	\$

(*Note: Total course costs should equal total funding sources)

Application Checklist

In support of your application please provide the following information:

- A completed application form
- A letter of support from the CEO of each participating facility
- Attach a brief statement (no more than 500 words) outlining the ongoing commitment to a learning culture within the participating organisations and how the training will impact upon future workforce outcomes. This should include:
 - Details about how the course/qualification/training resource will meet the identified needs of the partnership
 - Information regarding how this clinical supervision training course will contribute to increasing **quality** of student clinical placements
- Utilising the tables over, provide quantitative data regarding how this clinical supervision training course will contribute to increasing student clinical placement capacity (NB: please quantify current clinical placement days - students and disciplines - and the expected increase across participating facilities)

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2008 Student Placement Capacity

Facility Name	Setting	Discipline	Placement Days
Eg 1. Health Service 1	Aged Care	Division 2 nursing	50
Eg 2. Health Service 2	Community Health	Physiotherapist	10

2011 Estimated Student Placement Capacity

Facility Name	Setting	Discipline	Placement Days
Eg 1. Health Service 1	Aged Care	Division 2 nursing	75
Eg 2. Health Service 2	Community Health	Physiotherapist	17

TO CALCULATE CLINICAL PLACEMENT DAYS

A clinical placement day is defined as a student being on site for a minimum seven hour work day. Where the hours are less than this, they must be added together and divided by 7 to equate to a 'day'.

For example: two students on placement for seven weeks, four days per week and five hours per days equals 40 placement days ie. $(2 \times 7 \times 4 \times 5)/7 = (280/7) = 40$.

(* Please provide clinical placement day information for the 2008 calendar year and estimate for the 2011 calendar year)

Declaration (to be signed by lead agency endorsement delegate)

In submitting this application to the Clinical Supervision Grants Program in accordance with the guidelines, I agree to the terms and conditions of the grant program, to participate in program evaluations as requested and that all information provided in this application is true and correct.

Signature of Lead Agency Contact

Signature of Lead Agency Chief Executive Officer

Date of Application

Completed applications should be forwarded, along with other required documents, to;

Clinical Supervision Grants Program
The Victorian Healthcare Association
Level 6, 136 Exhibition Street
MELBOURNE VIC 3000